DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/02/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445205	A. BUILDING _____ B. WING _____	01/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF CHATTANOOGA	8249 STANDIFER GAP ROAD CHATTANOOGA, TN 37421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey and complaint investigation #39706, #40137, #40236, #40293, #40321, #40385, #39812, and #40386 were conducted from 1/8/17 through 1/19/17 at Consulate Health Care of Chattanooga. No deficiencies were cited related to the complaints.	F 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations.	
F 282 SS=G	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility investigations, interview, and observations, the facility failed to implement the care plan interventions for prevention of falls for 1 resident (#1) of 5 residents reviewed for falls, of 45 sampled residents, resulting in a head laceration requiring sutures (harm) for Resident #1. The findings included: Medical record review revealed Resident #1 was admitted to the facility on 4/10/15 with diagnoses including Senile Dementia, Diabetes Mellitus Type 2, Hypertension, Chronic Kidney Disease, Diverticulitis, and Depressive Disorder. Medical record review of the Annual Minimum Data Set (MDS) dated 6/19/16 revealed Resident	F 282	**F282 483.21(c)(3)(ii) Services By Qualified Persons/Per Care Plan** 1. Resident #1 care plan reviewed and/or updated on 2/7/2017 to reflect resident's current fall interventions by the Director of Clinical Services. 2. Observations of current residents at risk for falls was completed 2/6/2017-2/9/2017 to validate current fall interventions, based on the care plan were in place by the Director of Clinical Services and/or Nursing Supervisor. No issues identified. 3. The Director of Clinical Services and/or Nursing Supervisor in serviced current Certified Nurse Assistants, Licensed Nurses on making sure that fall interventions are in place on residents at risk for falls based on the	2/17/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

EXECUTIVE DIRECTOR 2/21/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 282	Continued From page 1 #1 had a Brief Interview for Mental Status (BIMS) score of 8 out of a possible 15, which indicated moderate cognitive impairment. Continued review revealed the resident required extensive assistance of one person for all activities of daily living. Medical record review of the care plan dated 7/1/16 revealed "...Safety...Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed...W/C [wheelchair] alarm..." Medical record review of a nurse's note dated 9/10/16 at 7:50 PM, revealed "...found lying on the floor in front of her W/C with a laceration in the center of her head..." Medical record review of a nurse's note dated 9/11/16 at 8:35 AM, revealed "...Returned to facility via EMS [Emergency Medical Services] ...stitches to forehead covered with drsg [dressing]..." Review of a facility investigation dated 9/13/16 revealed "...Date of Occurrence 9/10/16...Locomotion Status: W/C [wheel chair] bound...Transfer status: extensive assist...sitting in W/C in her room...Summary: Resident sent to ER [Emergency Room] status post fall with laceration to head..." Further review of the investigation revealed the resident was supposed to have a pressure alarm in place in the wheelchair at the time of the fall, as care planned 7/1/16. Telephone interview with Certified Nursing Assistant (CNA) #8 on 1/12/17 at 10:35 AM, who was with Resident #1 after the fall on 9/10/16,	F 282	Continued from page 1 care plan/kardex 2/8/2017-2/15/2017. Future employees will be in serviced on this during orientation by the Staff Development Coordinator. The Director of Clinical Services and/or Nursing Supervisor will perform Quality Improvement Monitoring of residents at risk for falls for fall interventions being in place beginning 2/14/2017 5 times a week for 1 month, 3 times a week for 1 month, 2 times a week for 1 month and then monthly thereafter for one year. 4. The Director of Clinical Services introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 2/10/2017. The results of this quality monitoring will be reported to the Quality Assurance Performance Improvement Committee members monthly for three months then quarterly thereafter for a year. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Unit Manager, Staff	

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F 282	Continued From page 2 confirmed Resident #1 did not have a pressure alarm in the wheelchair at the time of the fall and CNA #8 could not recall if the call light was within reach. Interview with Licensed Practical Nurse #7 on 1/17/17 at 12:30 PM, in the conference room, confirmed Resident #1's care plan at the time of the fall on 9/10/16 identified the need for interventions to prevent falls, which included the need of a pressure alarm in the wheelchair. The failure to ensure the care plan interventions were implemented to prevent falls resulted in a fall with a head laceration requiring sutures for Resident #1. Refer to F323	F 282	Continued from page 2 Development, Activities, Medical Director, Social Services, Maintenance Director, Dietary Manager and Minimum Data Set Coordinator.	
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.	F 323	**F323 483.25(d)(1)(2)(n)(1)-(3) Free of Accident Hazards/Supervision/Devices** 1. Resident #1 care plan reviewed and/or updated on 2/6/2017 to reflect residents current fall interventions by the Director of Clinical Services. Observations of residents care plan interventions from falls by the Director of Clinical Services was completed on 2/6/17 with no issues identified. Resident #48 dycem was replaced in wheelchair on 1/11/2017 by the Director of Clinical Services.	2/17/17

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F 323	Continued From page 3 (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of a facility investigation, interviews, and observations, the facility failed to ensure assistive devices were in place to prevent falls for 2 residents (#1, #48) of 5 residents reviewed for falls, of 45 sampled residents, resulting in a head laceration which required sutures (harm) for Resident #1. The findings included: Medical record review revealed Resident #1 was admitted to the facility on 4/10/15 with diagnoses including Senile Dementia, Diabetes Mellitus Type 2, Hypertension, Chronic Kidney Disease, Diverticulitis, and Depressive Disorder. Medical record review of Resident #1's annual Minimum Data Set (MDS) dated 6/19/16 revealed Resident #1 scored a 8 out of 15 on the Brief Interview for Mental Status (BIMS), which indicated the resident had moderate cognitive impairment. Continued review revealed the resident required extensive assistance with all activities of daily living with 1 staff person to assist. Medical record review of the care plan dated 7/1/16 revealed "...Safety...Be sure the resident's	F 323	Continue from page 3 2. Observations of current residents at risk for falls was completed 2/6/2017-2/9/2017 to validate current fall interventions based on the care plan were in place by the Director of Clinical Services and/or Nursing Supervisor. No issues identified. 3. The Director of Clinical Services and/or Nursing Supervisor in serviced Current Certified Nurse Assistants, Licensed Nurses on making sure that fall interventions are in place on residents at risk for falls based on the care plan/kardex 2/8/2017-2/15/2017. Future employees will be in serviced on this during orientation by the Staff Development Coordinator . The Director of Clinical Services and/or Nursing Supervisor will perform Quality Improvement Monitoring of residents at risk for falls for fall interventions being in place beginning 2/14/17, 5 times a week for 1 month, 3 times a week for 1 month, 2 times a week for 1 month and then monthly thereafter for one year. 4. The Director of Clinical Services	

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F 323	Continued From page 4 call light is within reach and encourage the resident to use it for assistance as needed...W/C [wheelchair] alarm..." Medical record review of the nurses note dated 9/10/16 at 7:50 PM, revealed "...found lying on the floor in front of her W/C with a laceration in the center of her head..." Medical record review of a hospital emergency department record dated 9/10/16 at 23:13 (11:13 PM) revealed "...Laceration-Single Repair...subcutaneous fascia closed...3 sutures, Skin layer closed, greater than 10 sutures interrupted..." Medical record review of a nurse note dated 9/11/16 at 3:35 AM, revealed "...Returned to facility via EMS [Emergency Medical Services] transferred into bed...stitches to forehead covered with dreg [dressing]..." Review of a facility investigation dated 9/13/16 revealed "...Date of Occurrence 9/10/16...Locomotion Status: W/C [wheelchair] bound...Transfer status: extensive assist...call bell...Alarm in use...pressure alarm...[indicating interventions that should have been in place at the time of the fall were a call bell and pressure alarm]...What activity, event, environment...was resident engaged in prior to the fall or at time of fall?...sitting in W/C in her room...Summary: Resident sent to ER [Emergency Room] status post fall with laceration to head." Telephone interview with Certified Nurse Aide (CNA) #8 on 1/12/17 at 10:35 AM, who was the CNA with the resident after the fall on 9/10/16, confirmed Resident #1 did not have a pressure	F 323	Continued from page 4 introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 2/10/2017. The results of this quality monitoring will be reported to the Quality Assurance Performance Improvement Committee members monthly for three months then quarterly thereafter for a year. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services; Unit Manager, Staff Development, Activities, Medical Director, Social Services, Maintenance Director, Dietary Manager and Minimum Data Set Coordinator.	

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F 323	Continued From page 5 alarm in the wheelchair at the time of the fall, and CNA #8 could not recall if the call light was within reach at the time of the fall. Interview with Licensed Practical Nurse (LPN) #7 on 1/17/17 at 12:30 PM, in the conference room, confirmed Resident #1 was supposed to have a pressure alarm in her wheelchair to prevent falls at the time of the fall on 9/10/16. The failure to ensure assistive devices to prevent falls were in place resulted in a fall with a head laceration requiring sutures for Resident #1. Medical record review revealed Resident #48 was admitted to the facility on 4/4/08 with diagnoses including Dementia without Behavioral Disturbances, Abnormal Posture, Contracture, and Schizophrenia. Medical record review of Resident #48's quarterly MDS dated 10/30/16 revealed the resident had severe cognitive impairment. Continued review revealed the resident was totally dependent for transfers, dressing, eating, personal hygiene and bathing with 1-2 person assist. Review of a facility investigation dated 12/9/16 revealed the resident had fallen from his wheelchair and no injuries were sustained from the fall. Continued review revealed, to prevent further falls, the intervention implemented after this fall was to place a dycem in the seat of the wheelchair. Medical record review revealed Resident #48's care plan was updated to reflect the new intervention for fall prevention, "...Safety...dycem [non slip surface] to W/C [wheel chair] seat..."	F 323		

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F 323	Continued From page 6 Interview with CNA #3 on 1/11/17 at 10:40 AM, on the 200 hallway, revealed "...not sure if he [Resident #48] is supposed to have anything in his wheelchair seat or not..." Observation of Resident #48 with the Director of Nursing (DON) on 1/11/17 at 2:05 PM, in the resident's room, confirmed there was no dycem in the resident's wheelchair seat. Interview with the DON on 1/18/17 at 8:35 AM, in her office, confirmed the facility failed to ensure safety devices were in place at the time of the fall for Resident #1 which resulted in a fall with a head laceration requiring stitches (harm) for Resident #1, and failed to ensure safety devices were in place for Resident #48. Refer to F282	F 323		
F 502 SS=D	483.50(a)(1) ADMINISTRATION (a) Laboratory Services (1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure laboratory tests were completed for 1 resident (#58) of 46 residents reviewed. The findings included: Medical record review revealed Resident #58 was	F 602	**F502 483.50(a)(1) Administration** 1. Resident #58 physician was notified on 1/18/17 of the missing labs by the Assistant Director of Clinical Services. New orders were obtained. 2. The Director of Clinical Services and/or Nursing Supervisor reviewed the last 90 days worth of lab orders to validate results obtained 1/30/2017. 3. The Director of Clinical Services and/or Nursing Supervisor in serviced	2/17/17

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F 502	Continued From page 7 admitted to the facility on 12/27/11 with diagnoses including Conduct Disorder, Acute Respiratory Failure, Convulsions, Psychosis, Major Depressive Disorder, Anxiety Disorder, and Hypertension. Medical record review of the Physician's Recapitulation Orders dated December 2016, revealed "...CBC [Complete Blood Count], CMP [Complete Metabolic Panel] Every 6 months (Jun [June]/Dec [December])...Valproic Acid Level every 3 months (March/June/Sept [September]/Dec)..." Medical record review revealed there were no laboratory results for December. Interview with the Assistant Director of Nursing on 1/18/17 at 3:40 PM, in the conference room, confirmed the CBC, CMP, and Valproic Acid level were not done in December 2016.	F 502	Continued from page 7 current licensed nurses on processing orders for labs 2/8/2017-2/15/2017. Future employees will be in serviced on this during orientation by the Staff Development Coordinator. The Director of Clinical Services and/or Nursing Supervisor will perform Quality Improvement Monitoring of labs ordered and results beginning 2/14/17, 5 times a week for 1 month, 3 times a week for 1 month, 2 times a week for 1 month and then monthly thereafter for 1 year. 4. The Director of Clinical Services introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 2/10/2017. The results of this quality monitoring will be reported to the Quality Assurance Performance Improvement Committee members monthly for three months then quarterly thereafter for a year. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Unit Manager, Staff	
F 514 SS=D	483.70(l)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (l) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 514		

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F 514	Continued From page 8 (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on medical record review and interviews, the facility failed to maintain a complete and accurately documented clinical record for 2 residents (#36 and #134) of 6 residents reviewed for care and treatment of pressure and non-pressure skin conditions, of 45 sampled residents. The findings included: Medical record review revealed Resident #36 was admitted to the facility on 3/10/15 with diagnoses including Polyosteoarthritis, Methicillin-resistant Staphylococcus aureus (MRSA), Difficulty Walking, Muscle Weakness, Chronic Pain, Osteoporosis, Cognitive Deficit, Diabetes Mellitus Type II, Hypertension, Atrial Fibrillation, and Dementia.	F 514	Continued from page 8 Development, Activities, Medical Director, Social Services, Maintenance Director, Dietary Manager and Minimum Data Set Coordinator. **F514 483.70(i)(1)(5) Res Records-Complete/Accurate/Accessible** 1. Resident #36 no longer resides at the facility. Resident #134 no longer resides at the facility. 2. The Director of Clinical Services and/or Nursing Supervisor reviewed the last 30 days of Medication Administration Records, Treatment Records for omissions 1/30/2017. Issues identified were addressed by the Director of Clinical Services. 3. The Director of Clinical Services and/or Nursing Supervisor in serviced current Licensed Nurses on accurate medical records, no omissions in the medical record 2/8/2017-2/15/2017. The Director of Clinical Services and/or Nursing Supervisor will perform Quality Improvement Monitoring of residents Medication Administration	2/17/17

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F 514	Continued From page 9 Medical record review of the Treatment Record for 9/1/16 - 9/30/16 revealed "...L [left] posterior knee: Clean with N/S [normal saline] pat dry: Apply 1 inch Iodoform packing into wound. Cover with abd [abdominal] pad and tape. Change QOD [every other day]..." Continued review of the Treatment Record revealed wound care was documented on 9/23 and 9/26/16, but there was no documentation for 9/25/16, a date the dressing was due to be changed. Interview with Licensed Practical Nurse (LPN) #9 on 1/12/17 at 9:00 AM, at the West Wing Nurses Station, confirmed the dressing was changed every other day, but at times required changing daily, depending on the amount of drainage. Further interview with LPN #9 confirmed "I know" the treatment was completed, but was not always documented. Interview with the Director of Nursing (DON) on 1/18/17 at 9:10 AM, in her office, confirmed the wound care for Resident #36 was documented on 9/23/16 and 9/26/16, and the documentation for wound care should have been documented at least every other day, which would have included 9/25/16, making the documentation 1 day late. Medical record review revealed Resident #134 was admitted to the facility on 8/4/16 with diagnoses including Surgical Aftercare Following Surgery of the Digestive System, Fistula of Intestines, Obesity, Major Depressive Disorder, Hypertension, Atrial Fibrillation, Chronic Obstructive Pulmonary Disease (COPD), and Generalized Anxiety Disorder. Medical record review of a physician's telephone	F 514	Continued from page 9 Record and Treatment Record for omissions beginning 2/14/17, 5 times a week for 1 month, 3 times a week for 1 month, 2 times a week for 1 month and then monthly thereafter for one year. 4. The Director of Clinical Services introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 2/10/2017. The results of this quality monitoring will be reported to the Quality Assurance Performance Improvement Committee members monthly for three months then quarterly thereafter for a year. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Unit Manager, Staff Development, Activities, Medical Director, Social Services, Maintenance Director, Dietary Manager and Minimum Data Set Coordinator.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF CHATTANOOGA	6249 STANDIFER GAP ROAD CHATTANOOGA, TN 37421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 10 order dated 9/16/16 revealed "...wnd [wound] vac to be changed q [every] 3-4 days. Cleanse wnd cleanser, apply black foam wnd bed and secure plastic drape dsg [dressing]..." Medical record review of the 9/16 and 10/16 Treatment Records revealed no documentation of wound vac changes from 9/23/16 through 10/5/16 (12 days). An undated sticky note was attached to the 10/16 Treatment Record, with LPN #9's signature, which stated "Refused to be changed states she wants to wait till Monday to change..." Telephone interview with LPN #9 on 1/17/17 at 12:06 PM, confirmed the resident did refuse dressing changes at times and only wanted it done if it was "absolutely necessary." Continued interview confirmed the treatment records were not accurately documented when the treatments were done and when the resident refused. Interview with the Regional Director of Clinical Services on 1/17/17 at 12:30 PM, in the Conference Room, confirmed there was no documentation of wound vac changes for Resident #134 from 9/23/16 through 10/5/16 (12 days).	F 514		
F 520 SS=G	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services;	F 520	**F520 483.76(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA Committee-Members/Meet Quarterly/Plans** 1. Facility has Quality Assurance Performance Improvement committee in place and implements plans for improvement and monitors and revises as needed through the QAPI process.	2/17/17

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	445206	A. BUILDING _____ B. WING _____	01/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 520	Continued From page 11 (II) The Medical Director or his/her designee; (III) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (I) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (II) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on review of Provider History Profile, medical record review, and interview, the facility failed to ensure an effective Quality Assurance (QA) program that recognized an ongoing concern with preventing falls and accurate medical records. The QA committee failed to	F 520	Continued from page 11 2. The Regional Director of Clinical Services re-educated the interdisciplinary team members on regulation F520 and the facility's policy and procedures for Quality Assurance Performance Improvement on 2/9/2017. Observations of current residents at risk for falls was completed 2/6/2017-2/9/2017 to validate current fall interventions based on the care plan were in place by the Director of Clinical Services and/or Nursing Supervisor. No issues identified. The Director of Clinical Services and/or Nursing Supervisor reviewed the last 30 days of Medication Administration Records, Treatment Records for omissions 1/30/2017. Issues identified were addressed by the Director of Clinical Services. 3. The Director of Clinical Services and/or Nursing Supervisor in serviced Current Certified Nurse Assistants, Licensed Nurses on making sure that fall interventions are in place on residents at risk for falls based on the care plan/kardex 2/8/2017-2/15/2017.	

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F 520	Continued From page 12 ensure systems and processes were in place and consistently followed by staff to address quality concerns. The facility failed to ensure the QA program was effective in preventing repeat deficiencies at F-323 and F-514. The facility failed to prevent accidents, which resulted in a fall with a head laceration (Harm) for Resident #1. The findings included: Review of the Provider History Profile dated 12/12/16 revealed the facility was cited F-323 during the annual Recertification survey on 1/27/16 for failure to ensure interventions were in place to prevent falls. Continued review revealed F-514 was cited during the annual Recertification surveys on 12/9/14 and 1/27/16, for failure to maintain a complete and accurate medical record. During the annual Recertification survey conducted from 1/8/17 through 1/19/17, the facility's QA Committee failed to ensure a system for management of safety devices resulting in 1 resident (#1) receiving a fall with injury, 1 resident (#48) with an observation of a safety device not in place, and 2 residents (#36, #134) not having accurate documentation in the medical record, of 45 residents reviewed during stage 2. Interview with the Regional Director of Clinical Services and the Administrator on 1/19/17 at 11:15 AM, in the conference room, confirmed the QA committee had not identified a problem with falls and safety devices not being in place and had not identified incomplete documentation in the medical record as areas to be addressed with corrective actions.	F 520	Continued from page 12 Future employees will be in serviced on this during orientation by the Staff Development Coordinator. The Director of Clinical Services and/or Nursing Supervisor will perform Quality Improvement Monitoring of residents at risk for falls for fall interventions being in place beginning 2/14/17, 5 times a week for 1 month, 3 times a week for 1 month, 2 times a week for 1 month and then monthly thereafter for one year. The Director of Clinical Services and/or Nursing Supervisor in serviced current Licensed Nurses on accurate medical records, no omissions in the medical record 2/8/2017-2/15/2017. The Director of Clinical Services and/or Nursing Supervisor will perform Quality Improvement Monitoring of residents Medication Administration Record and Treatment Record for omissions beginning 2/14/17, 5 times a week for 1 month, 3 times a week for 1 month, 2 times a week for 1 month and then monthly 4. The Executive Director introduced the plan of correction to the Quality	

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	445208	A. BUILDING _____ B. WING _____	01/19/2017

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F 520	Continued From page 13 Refer to F282, F323, F514	F 520	Continued from page 13 Assurance Performance Improvement Committee on 2/10/2017. The results of this quality monitoring will be reported to the Quality Assurance Performance Improvement Committee members monthly for three months then quarterly thereafter for a year. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Unit Manager, Staff Development, Activities, Medical Director, Social Services, Maintenance Director, Dietary Manager and Minimum Data Set Coordinator.	